The Wyoming Department of Health Preventive Health and Safety Division Report to the Governor, Wyoming Healthcare Commission and The Joint Labor, Health, and Social Services Interim Committee

Fifth Annual Report on Adverse Health Events in Wyoming Healthcare Facilities

Compiled by Linda Chasson, M.S., Administrator, Preventive Health and Safety Division

Edited by
Ginny Mahoney, M.A.
Deputy Director of Rural and Public Health and Aging Division Administrator

Brent D. Sherard, M.D., M.P.H., F.A.C.P Director and State Health Officer Wyoming Department of Health W.S. § 35-2-912

Wyoming Department of Health Preventive Health and Safety Division (048)

Website: http://wdh.state.wy.us/PHSD/index.html

Email: <u>katie.bryan@health.wyo.gov</u> Cheyenne, Wyoming 82002

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1. General Comments/Overview/Executive Summary

The objective of this report is to meet the requirements of W.S. § 35-2-912, which states in pertinent part:

"On or before December 31 of each year beginning in 2006, the Department of Health shall prepare and publish a report and analysis of all reported safety events for the previous year, including a trend analysis and recommendations for systemic improvements that are likely to enhance patient safety and health care. The Department may convene a panel of health care experts to review the data and compile the report. The report shall be made available to the public and copies forwarded to the Governor, the Healthcare Commission, and Joint Labor, Health, and Social Services Interim Committee. In its annual report and any other public document, the Department shall ensure that all referenced information is aggregated so as not to reveal the identity of any specific person or health care facility."

The following report describes the events reported during the fifth year (July 1, 2009 through June 30, 2010) and this information will be compared to data from fiscal years 2008 and 2009. In congruence with the statute, and in order to create a culture of safety and to encourage the accurate reporting of adverse events, no one facility has been identified in this report and all data has been aggregated.

2. Specific Requirements of Statute

The data utilized for this analysis was collected by the Wyoming Department of Health (WDH) from July 1, 2005 through June 30, 2010. Healthcare facilities were enrolled in the Mandatory Reporting of Safety Events System. Each facility designated a Patient Safety Officer (PSO), who was tasked with reporting adverse health events to WDH. Our analysis focused on aggregate healthcare data for the reporting categories outlined in W.S. 35-2-912: Mandatory Reporting of Safety Events. Six categories, outlined in Table 1, were analyzed and resulting death or disability was reported for events occurring within the categories. The analysis focused on a comparison between fiscal years 2008, 2009, and 2010 to identify trends. EpiInfo, version 3.5.1, was the statistical package used to extract and analyze the data.

Table 1: Categories of Reportable Events as Defined by Law*

SURGICAL EVENTS

- Surgery performed on a wrong body part;
- Surgery performed on the wrong patient;
- The wrong surgical procedure performed on a patient;
- Foreign objects left in a patient after surgery; or
- Death during or immediately after surgery of a normal, healthy patient.

PRODUCT OR DEVICE EVENTS

- The use of contaminated drugs, devices, or biologics;
- The use or malfunction of a device in patient care; or
- An intravascular air embolism.

PATIENT PROTECTION EVENTS

- An infant discharged to the wrong person;
- Patient death or serious disability associated with patient disappearance; or
- Patient suicide or attempted suicide resulting in serious disability.

CARE MANAGEMENT EVENTS

- Associated with a medication error;
- Associated with a reaction due to incompatible blood or blood products;
- Associated with labor or delivery in a low-risk pregnancy;
- Directly related to hypoglycemia (low blood sugar);
- In newborn infants during the first 28 days of life associated with hyperbilirubinemia;
- Due to spinal manipulative therapy; or
- Stage 3 or 4 ulcers (very serious pressure sores) acquired after admission to a facility.

ENVIRONMENTAL EVENTS

- An electric shock;
- A burn incurred while being cared for in a facility;
- A fall while being cared for in a facility;
- The use or lack of restraints or bedrails while being cared for in a facility; or
- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances.

CRIMINAL EVENTS

- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider;
- Abduction of a patient of any age;
- Sexual assault on a patient within or on the grounds of a facility; or
- Death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.

^{*}Detailed definitions are included in Appendix B

3. Consequences/Outcomes

- During the first year (Fiscal Year 2006), 19 facilities of 199 (9.5%) reported a total of 58 adverse health events, of which 23 events resulted in serious disability and 6 resulted in death. Although 19 facilities reported events, it is likely that reporting was incomplete, and the events were not representative of all adverse events occurring within the state.
- During the second year (Fiscal Year 2007), 21 facilities of 205 (10.2%), reported a total
 of 43 adverse health events, of which 20 events resulted in serious disability and 4
 resulted in death. Although 21 facilities reported events, it was likely that reporting was
 incomplete and the events were not representative of all adverse events occurring in the
 state.
- During the third year (Fiscal Year 2008), 16 facilities of 200 (7.5%) (Table 2), reported a total of 43 adverse health events, of which 25 events resulted in serious disability and 2 resulted in death. Although 16 facilities reported events, it was likely that reporting was incomplete and the events were not representative of all adverse events occurring in the state.
- During the fourth year (Fiscal Year 2009), 18 facilities of 236 (7.6%) (Table 2), reported a total of 42 adverse health events, of which 13 events resulted in serious disability and 5 resulted in death. Although 18 facilities reported events, it was likely that reporting was incomplete and the events were not representative of all adverse events occurring in the state.
- During the fifth year (Fiscal Year 2010), 15 facilities of 237 (6.3%) (Table 2), reported a total of 31 adverse health events, of which 15 events resulted in serious disability and 5 resulted in death. Although 15 facilities reported events, it was likely that reporting was incomplete and the events were not representative of all adverse events occurring in the state.

Table 2: Statewide Numbers for Facility Type (FY 2010)

Type of Facility	Current Statewide Number
Adult Daycare Facilities	8
Ambulatory Surgical Centers	19
Assisted Living Facilities	22
Boarding Homes	11
Community Mental Health Centers	3
Comprehensive Outpatient Rehabilitation Centers	1
Critical Access Hospitals	16
End Stage Renal Dialysis Centers	9
Federally Qualified Health Centers	9
Free Standing Diagnostic Testing Centers	1
Home Health Agencies	42
Hospices	21
Hospitals	12
Intermediate Care Facility for the Mentally Retarded	1
Nursing Care Facilities	38
Outpatient Physical Therapy/Speech Clinics	1
Psychiatric Hospitals	2
Psychiatric Residential Treatment Facilities	3
Rehabilitation Facilities	1
Rural Health Clinics	17
Total Number of Facilities	237

The total numbers of events reported in each category were analyzed (Tables 3A-3F). In addition, a comparison was made between the third, fourth, and fifth years of reporting. Table 4 summarizes the adverse events reported to WDH during the 2008, 2009, and 2010 Fiscal Years.

Tables 3A-3F: Statewide Reports by Category (FY 2010)

3A Surgical									
Wrong body part Wrong patient Wrong procedure Foreign object retention T						Total			
Frequer	псу	1	0	0	3	0	4		
Severity	details								
	Disability	0	-	-	0	-	0		
	Death	0	-	-	0	-	0		

3B Products or Devices*								
		Contaminated drugs, devices, or biologics	Misuse or malfunction of device	Intravascular air embolism	Total for Products or devices			
Frequen	су	0	0	0	0			
Severity	details							
Disability		-	-	-	0			
	Death	-	-	-	0			
* No ev	ents were rep	orted in this category for	FY 2010					

3C Patient Protection							
		Wrong discharge of infant	Patient disappearance	Suicide or attempted suicide	Total for Patient Protection		
Frequency		0	1	0	1		
Severity details							
	Disability	-	0	-	0		
	Death	-	1	-	1		

3]	3D Care Management								
		Medication error	Hemolytic reaction	During low- risk pregnancy, labor, or delivery	Hypo- glycemia	Failure to treat hyper- bilirubin- emia	Stage 3 or stage 4 pressure ulcers acquired after admission	Spinal manipu- lation	Total for Care Mgmt
Fı	requency	4	0	0	1	0	3	0	8
	everity etails								
	Disability	0	-	-	0	-	2	-	2
	Death	0	-	-	1	-	0	-	1

31	3E Environmental							
		Electric shock	Wrong gas or contamination in patient gas line	Burns	Injury associated with a fall	Restraints	Total for Environmental	
Fı	requency	0	0	0	18	0	18	
Se	everity details							
	Disability	-	-	-	13	-	13	
	Death	-	-	-	3	-	3	

3F Criminal*								
	Care ordered by someone impersonating a physician, nurse, or other provider	Abduction of patient	Sexual assault of a patient	Death or injury of patient or staff from physical assault	Total for Criminal			
Frequency	0	0	0	0	0			
Severity details								
Disability	-	-	-	-	0			
Death	-	-	-	-	0			
* No events were	reported in this category for	or FY 2010						

Table 4: Summary of Adverse Health Events Reported (July 2007 – June 2010)

Total Events	Total Events								
	Frequency (%) (Number of Events)			Ι	Disability	,	Death		
	FY 2008	FY 2009	FY 2010	FY 2008	FY 2009	FY 2010	FY 2008	FY 2009	FY 2010
Surgical	2 (4.7)	7 (16.7)	4 (12.9)	0	0	0	0	1	0
Products or Devices	0 (0)	0 (0)	0 (0)	0	0	0	0	0	0
Patient Protection	0 (0)	0 (0)	1 (3.2)	0	0	0	0	0	1
Care Management	14 (32.6)	14 (33.3)	8 (25.8)	2	0	2	0	3	1
Environmental	25 (58.1)	20 (47.6)	18 (58.1)	23	13	13	2	1	3
Criminal	2 (4.7)	1 (2.4)	0 (0)	0	0	0	0	0	0
Total	43 (100)	42 (100)	31 (100)	25	13	15	2	5	5

In Fiscal Year 2010, 31 adverse health events were reported; 15 of the events resulted in serious disability, and 5 resulted in death. For the fifth consecutive year, care management and environmental events comprised the largest percentage of reported events (25.8% and 58.1%, respectively). Detailed events stratified by category are presented for Fiscal Years 2008, 2009, and 2010 in Tables 5A-5F.

Tables 5A-5F: Statewide Reports by Category (July 2007 - June 2010)

5A Sur	gical						
		Wrong body part	Wrong patient	Wrong procedure	Foreign object retention	Intra/Post-op death	Total
Freque	ency (%) FY 2008	0 (0.0)	0 (0.0)	0 (0.0)	2 (100)	0 (0.0)	2 (100)
Freque	ency (%) FY 2009	1 (14.3)	0 (0.0)	0 (0.0)	5 (71.4)	1 (14.3)	7 (100)
Freque	ency (%) FY 2010	1 (25.0)	0 (0.0)	0 (0.0)	3 (75.0)	0 (0.0)	4 (100)
S	everity details						
	Disability (%) FY 2008	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0)
	Disability (%) FY 2009	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0)
	Disability (%) FY 2010	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0)
	Death (%) FY 2008	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0)
	Death (%) FY 2009	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100)	1 (100)
	Death (%) FY 2010	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0)

5B Pro	oducts or Devices				
		Contaminated drugs, devices, or biologics	Misuse or malfunction of device	Intravascular air embolism	Total for Products or Devices
Freque	ncy (%) FY 2008	0 (0.0)	0 (0.0)	0 (0.0)	0 (0)
Freque	ncy (%) FY 2009	0 (0.0)	0 (0.0)	0 (0.0)	0 (0)
Freque	ncy (%) FY 2010	0 (0.0)	0 (0.0)	0 (0.0)	0 (0)
Severity	y details				
	Disability (%) FY 2008	0 (0.0)	0 (0.0)	0 (0.0)	0 (0)
	Disability (%) FY 2009	0 (0.0)	0 (0.0)	0 (0.0)	0 (0)
	Disability (%) FY 2010	0 (0.0)	0 (0.0)	0 (0.0)	0 (0)
	Death (%) FY 2008	0 (0.0)	0 (0.0)	0 (0.0)	0 (0)
	Death (%) FY 2009	0 (0.0)	0 (0.0)	0 (0.0)	0 (0)
	Death (%) FY 2010	0 (0.0)	0 (0.0)	0 (0.0)	0 (0)

5C Patient Protection				
	Wrong discharge of infant	Patient disappearance	Suicide or attempted suicide	Total for Patient Protection
Frequency (%) FY 2008	0 (0.0)	0 (0.0)	0 (0.0)	0 (0)
Frequency (%) FY 2009	0 (0.0)	0 (0.0)	0 (0.0)	0 (0)
Frequency (%) FY 2010	0 (0.0)	1 (100)	0 (0.0)	1 (100)
Severity details				
Disability (%) FY 2008	0 (0.0)	0 (0.0)	0 (0.0)	0 (0)
Disability (%) FY 2009	0 (0.0)	0 (0.0)	0 (0.0)	0 (0)
Disability (%) FY 2010	0 (0.0)	0 (0.0)	0 (0.0)	0 (0)
Death (%) FY 2008	0 (0.0)	0 (0.0)	0 (0.0)	0 (0)
Death (%) FY 2009	0 (0.0)	0 (0.0)	0 (0.0)	0 (0)
Death (%) FY 2010	0 (0.0)	1 (100)	0 (0.0)	1 (100)

5D Care Management								
	Medication error	Hemolytic reaction	During low-risk pregnancy, labor, or delivery	Hypo- glycemia	Failure to treat hyper- bilirubin- emia	Stage 3 or stage 4 pressure ulcers acquired after admission	Spinal manipu -lation	Total for Care Mgmt
Frequency (%)								14
FY 2008	11(78.6)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	3 (21.4)	0 (0.0)	(100)
Frequency (%) FY 2009	7 (50.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	7 (50.0)	0 (0.0)	14 (100)
Frequency (%) FY 2010	4 (50.0)	0 (0.0)	0 (0.0)	1 (12.5)	0 (0.0)	3 (42.9)	0 (0.0)	8 (100)
Severity details								
Disability (%) FY 2008	2 (100)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	2 (100)
Disability (%) FY 2009	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0)
Disability (%) FY 2010	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	2 (100)	0 (0.0)	2 (100)
Death (%) FY 2008	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0)
Death (%) FY 2009	2 (66.7)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)	3 (100)
Death (%) FY 2010	0 (0.0)	0 (0.0)	0 (0.0)	1 (100)	0 (0.0)	(0.0)	0 (0.0)	1 (100)

5E Environmental						
	Death or disability associated with an electric shock	Wrong gas or contamination in patient gas line	Death or disability associated with a burn	Death or injury associated with a fall*	Death or disability associated with restraints	Total for Environmental
Frequency (%) FY 2008	0 (0.0)	0 (0.0)	0 (0.0)	25 (100.0)	0 (0.0)	25 (100)
Frequency (%) FY 2009	0 (0.0)	0 (0.0)	0 (0.0)	20 (100.0)	0 (0.0)	20 (100)
Frequency (%) FY 2010	0 (0.0)	0 (0.0)	0 (0.0)	18 (100.0)	0 (0.0)	18 (100)
Severity details						
Disability (%) FY 2008	0 (0.0)	0 (0.0)	0 (0.0)	23 (100.0)	0 (0.0)	23 (100)
Disability (%) FY 2009	0 (0.0)	0 (0.0)	0 (0.0)	13 (100.0)	0 (0.0)	13 (100)
Disability (%) FY 2010	0 (0.0)	0 (0.0)	0 (0.0)	13 (100.0)	0 (0.0)	13 (100)
Death (%) FY 2008	0 (0.0)	0 (0.0)	0 (0.0)	2 (100)	0 (0.0)	2 (100)
Death (%) FY 2009	0 (0.0)	0 (0.0)	0 (0.0)	1 (100)	0 (0.0)	1 (100)
Death (%) FY 2010	0 (0.0)	0 (0.0)	0 (0.0)	3 (100)	0 (0.0)	3 (100)

5F Criminal						
	Care ordered by someone impersonating a physician, nurse, or other provider	Abduction of patient	Sexual assault of a patient	Death or injury of patient or staff from physical assault	Total for Criminal	
Frequency (%) FY 2008	0 (0.0)	0 (0.0)	2 (100)	0 (0.0)	2 (100)	
Frequency (%) FY 2009	1 (100)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100)	
Frequency (%) FY 2010	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0)	
Severity details						
Disability (%) FY 2008	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0)	
Disability (%) FY 2009	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0)	
Disability (%) FY 2010	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0)	
Death (%) FY 2008	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0)	
Death (%) FY 2009	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0)	
Death (%) FY 2010	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0)	

4. Statistical Information

In order to complete the statistical analysis, EpiInfo version 3.5.1 was used to obtain descriptive statistics presented in Tables 3 through 5.

5. Recommendations

Not applicable.

6. Summation and Conclusion

Patient safety advocates should understand that events listed in this report represent a fraction of all of the procedures and admissions in Wyoming hospitals and healthcare facilities. With relatively low occurrence of adverse events, it is important to recognize that the number of reports from Wyoming facilities may differ from year to year for a variety of reasons. Wyoming hospitals and healthcare facilities vary in size and scope of medical practice. There is also variation in the number of admissions and in the number and types of procedures performed from year-to-year. In addition, the variations may stem from differences in reporting procedures, interpretation of the law, and the quality or safety of a hospital in general. As clearly and concisely as Wyoming law is written, there will be variation in what is reported based on interpretation of which events are reportable. Also, the level of awareness of healthcare staff in identifying potentially harmful situations and reporting them will cause variance in reporting. The Wyoming Department of Health, hospitals, and other patient safety stakeholders continue to work to reduce this disparity in interpretation and application of the law.

Healthcare providers in Wyoming hospitals are watching for potentially dangerous situations and subsequently reporting them with the intent to learn and prevent harm to patients. This reality is a major step forward in patient safety.

7. Appendices

Appendix A – Definitions

Adverse Event An untoward, undesirable, and usually unanticipated event, such as death of a patient, an employee, or a visitor in a healthcare organization. Incidents such as patient falls or improper administration of medications are also considered adverse events even if there is no permanent effect on the patient.¹

Aggregate Data Data collected and reported by organizations as a sum or total over a given time period, for example, monthly or quarterly.

Culture of Safety The product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management. Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures.²

Error The failure of a planned action to be completed as intended (i.e., error of execution) or the use of a wrong plan to achieve an aim (i.e., error of planning).

Patient Safety Freedom from accidental injury; ensuring patient safety involves the establishment of operational systems and processes that minimize the likelihood of errors and maximizes the likelihood of intercepting them when they occur.⁴

Disability "Person with a disability" means an individual who has a mental or physical impairment which substantially limits one or more major life activities.⁵

¹ Joint Commission on Accreditation of Healthcare Organizations, Sentinel Event Glossary of Terms, Online. Available at http://www.jointcommission.org/SentinelEvents/se_glossary.htm. [Accessed October 2006]

² Health and Safety Commission, Third Report of the Advisory Committee on the Safety of Nuclear Installations – Organizing for Safety, 1993.

³ National Quality Forum, Serious Reportable Events in Healthcare. Washington D.C., 2002.

⁴ Institute of Medicine, To Err is Human: Building a Safer Health System. Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, eds., Washington, D.C.: National Academy Press, 2000.

⁵ Wyoming State Statute 35-13-205. Available at http://legisweb.state.wy.us/statutes/titles/Title35/T35CH13AR2.htm. [Accessed October 2006]

Appendix B – Reportable Events as Defined in Wyoming Law

Below are the events that must be reported under the Mandatory Reporting of Safety Event System. This language is taken directly from Wyoming Statute 35-2-912.

Surgical Events

- 1. Surgery performed on a wrong body part that is not consistent with the documented informed consent for that patient. Reportable events under this clause do not include situations requiring prompt action that occur in the course of surgery or situations whose urgency precludes obtaining informed consent;
- 2. Surgery performed on the wrong patient;
- 3. The wrong surgical procedure performed on a patient that is not consistent with the documented informed consent for that patient. Reportable events under this clause do not include situations requiring prompt action that occur in the course of surgery or situations whose urgency precludes obtaining informed consent;
- 4. Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained; and
- 5. Death during or immediately after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

Product or Device Events

- 6. Patient death or serious disability associated with the use of contaminated drugs, devices or biologics provided by the facility when the contamination is the result of generally detectable contaminants in drugs, devices or biologics regardless of the source of the contamination or the product;
- 7. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. "Device" includes, but is not limited to, catheters, drains, and other specialized tubes, infusion pumps, and ventilators; and
- 8. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

Patient Protection Events

- 9. An infant discharged to the wrong person;
- 10. Patient death or serious disability associated with patient disappearance for more than four
- (4) hours, excluding events involving adults who have decision making capacity; and

11. Patient suicide or attempted suicide resulting in serious disability while being cared for in a facility due to patient actions after admission to the facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the facility.

Care Management Events

- 12. Patient death or serious disability associated with a medication error, including, but not limited to, errors involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose;
- 13. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products;
- 14. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within forty-two (42) days of post-delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy;
- 15. Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a facility;
- 16. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first twenty-eight (28) days of life. "Hyperbilirubinemia" means bilirubin levels greater than thirty (30) milligrams per deciliter;
- 17. Stage three (3) or four (4) pressure ulcers acquired after admission to a facility, excluding progression from stage two (2) to stage three (3) if stage two (2) was recognized at admission; and
- 18. Patient death or serious disability due to spinal manipulative therapy.

Environmental Events

- 19. Patient death or serious disability associated with an electric shock while being cared for in a facility, excluding events involving planned treatments such as electric counter shock;
- 20. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances;
- 21. Patient death or serious disability associated with a burn incurred from any source while being cared for in a facility;
- 22. Patient death or serious injury associated with a fall while being cared for in a facility; and
- 23. Patient death or serious disability associated with the use or lack of restraints or bedrails while being cared for in a facility.

Criminal Events

- 24. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider;
- 25. Abduction of a patient of any age;
- 26. Sexual assault on a patient within or on the grounds of a facility; and
- 27. Death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.